# Review of May 2, 2002 Health Steering Committee Meeting

## *1. Substantive Review of the Report Card*

We briefly reviewed the development of and substantive issues surrounding the report card. The legislature mandated its development. The report card designers established parameters, including the quest for a coherent vision, the extensive use of public health knowledge, a focus on health rather than disease, bringing a community perspective to the issue of health, and to select from among existing indicators.

Sources reviewed in the development were drawn from national public health, state and local public health, state and local community health, international public health, and life-course health. The sources focused on various aspects of health, including health results, health process and access to health care, prevention, and causal factors (environmental, social, behavioral).

The audiences for the report card were defined as the public, policy-makers, local public health officials, and private-sector health care insurers and providers. Its purposes are to engage and mobilize the public and policy-makers and to learn so as to improve the health status of the people in Washington State.

The report card is organized to separate health results from causal factors. Health results include

- Years of healthy life
- Perceived mental health
- Readiness to learn

The causal factors are organized around the Center for Disease Control health determinants model:

- Access to health care--10%
- Environment (physical and social)--20%
- Genetics--20%
- Health behaviors--50%

The outline for the report card review is attached at the end of this document.

## *2. Technical Review of the Report Card*

**Criteria for technical review of indicators**

- Valid
- Reliable
- Responsive

- Understandable
- Available
- Abuse-proof

**Key issues regarding data and indicators**

Generally the technical review committee recommends using rates per 100,000 instead of numbers. Rates provide consistency and also provide independence from population growth. Key proposed modifications are noted below. A complete outline of indicators and proposed modifications is attached to this document.

***Readiness to learn.*** An indicator had not been identified. The technical review committee suggests using the indicator "% of 3rd graders scoring above average on the composite ITBS reading and math."

***Illnesses commonly associated with unsafe food and water.*** Add "and poor hygiene" to the indicator. Remove Hepatitis A from list of illnesses. These illnesses are underreporting, so an increase in reporting could lead to an apparent increase.

Unsafe drinking water: % of population for whom drinking water systems are out of compliance with monitoring and all water quality standards. Data on Group A systems are currently available except only coliform and nitrates are readily available. Group A and B data will be available by approximately 2004. Percent of population will be estimated from connections.

Social connectedness. Civic involvement and inter-personal trust will be tested in the 2002 BRFSS. The review committee suggested indicating high school graduation rates with the proportion of 12th grade students who graduate (from OSPI).

Number of unintentional injuries. Suggestion—measure deaths resulting from injuries. Add an indicator of hospitalizations for falls in adults over 64 years.

Are we physically active? Healthy people asks about leisure time only. BRFSS asks about both leisure and work activity but the activities cannot be added.

Do we get good nutrition? Healthy people talks about servings—BRFSS asks about the number of times a day fruits and vegetables are consumed.

Adding a maternal/child health indicator? Current indicators that address MCH issues include readiness to learn, child abuse and neglect, and unmet needs for children. Unintentional injury could be disaggregated for 0-14 and 15-24. Two indicators suggested by DOH MCH are unintended pregnancies and infant mortality.

## *3. The Report Card and its Utility--Discussion.*

- It appears that many of the decisions around indicators were driven by the availability of data—e.g., high school graduation, readiness to learn, nutrition—and lack of data like emergency room data. There is some value in clarifying language, such as readiness to learn (at kindergarten); and in being more precise, such as differentiating between legal and illegal drugs. There is some inconsistency in that health status is used among some determinants like illness associated with unsafe food and water rather than the frequency of its occurrence.

- For the report card to be useful to the legislature, it will be necessary to have geographical breakdown of data. Currently perhaps half of the indicators can be broken down geographically. They want to know what the problem is and what they can do to solve it—more money, a bill, or a law. For example, what can they do about social connectedness?

- The report card needs to have an accompanying users guide with some suggestions about how the report card can be used to improve health—possible strategies and interventions. The report card is intended to be an educational device—to view health comprehensively. At this point there is a narrow understanding around health—the report card is an effort to broaden the perspective—to reeducate and build a data system that provides and supports that broader perspective. We have to connect the dots for people. The accompanying information will have to drill down—the report card is deceptively simple. There is a lot of embedded information in it.

- Regardless of audience, we need a discourse to demonstrate how it is meaningful to people in their lives in their communities. CD's and videos are mechanisms that might help with this. Tools need to be developed and made available. Why and So What need to be readily answered with respect to the report card. Policy implications at the local and state levels need to be articulated.

- Statistics are important, but we also need to tell stories that illustrate the issues and relationships we want people to be aware of. Stories can demonstrate the causes of health. We need to asses where we can get traction. What has been done successfully? What barriers need to be overcome? For example, a Spokane company addressed smoking and weight loss among its employees. Health promotion affects the bottom line. A healthy community provides a health workforce.

- The breadth of legislative actions profoundly affect health. For example, the seat belt law has substantial health benefits, but it tended to be debated more on libertarian/civil liberty grounds. The reason for looking at it as a public health issue is that we are spending substantial funds on illness and disease. There is great benefit to focusing on health instead.

- There is often some up-front cost to a focus on health. For example, paying for gym membership might eventually reduce hospitalization at a later stage. We should be focusing on causes not symptoms.

- We can't have an action neutral score card and expect anything to change. We need to go directly to community groups/institutions and not rely on the legislature.

### *4. Identification of Key Audiences—Individuals, Groups, Positions*.

The goal is to not just have useful information, but to have information that is actually used to improve the health of Washington State. The following target audiences were suggested for preliminary discussions about the report card's use:

1) employers, especially from the private sector
2) public education personnel
3) active PTA members or leaders
4) members or leaders from United Way boards
5) members or leaders of service groups such as the Rotary, Lions, or Kiwanis clubs
6) physicians

## *Substantive Review of the Report Card—Outline*

***Report Card on Washington's Health***

- Legislatively mandated
- Coherent vision
- Use extensive public health knowledge
- Focus on health, not disease
- Bring a community perspective to issue of health
- Select from Existing Indicators

**Existing Indicator Sets**

- Sources
  - National public health
  - State and local public health
  - State and local community health
  - International public health
  - Life-course health

- Foci
  - Health results
  - Health process and access to health care
  - Prevention
  - Causal factors
    - Environment
    - Social
    - Behavioral

**National Public Health Indicators**

- Healthy People 2010
- The Health of Canadians
- National Public Health Performance Standards

**State and Local Public Health Indicators**

- The Health of Washington State
- Oregon Benchmarks (Health)
- Communities Working Together for a Healthier New York
- Healthy Minnesotans
- Counties in Washington State
- Jacksonville, Florida
- Pasadena, California
- The Social Health of the Nation
- Community Counts 2000: Social and Health Indicators in King County
- The United Way State of Caring Index
- The Joint Center for Sustainable Communities
- Family Policy Council Thriving Families
- Mobilizing for Action Through Planning and Partnership (MAPP)

**International Public Health Indicators**
- Years of Healthy Life
- EuroQOL
- HUI-I
- Quality of Well-Being Scale
- World Health Organization Disability Assessment Schedule II

**Health Across the Life-Course**
- The Social Health of the Nation
- The California Health Report Indicator Set
- Washington Kids Count
- America's Children: Key National Indicators of Well-Being 2000
- Child and Adolescent Health Measurement Initiative
- The Maternal and Child Health Bureau

**Health Care System Indicator**
- The Pulse Indicators: Taking the Pulse of Washington's Health System

**Key Framework Issues**
- Audiences
- Purposes and accountability
- Focus of the indicators

**Audiences**
- Public
- Policy makers
- Local public health officials
- Private-sector health care insurers and providers

**Purpose and Accountability**
- Engage and mobilize the public and policy makers
- Learn so as to improve the health status of people in Washington State
- Accountability associated with the report card is of Public health, broadly conceived

**Focus of Indicators**
- Health status (results)
  - Physical, mental, child health
- Causal factors of health
  - Healthy behaviors/individual risk
  - Social/economic/community factors
  - Environment
- Health care system

**Operating Guidelines**
- Standards for including causal indicators

    - Based on the best science available
    - Use "robust" measures—meta-determinants
- Focus on health rather than disease
- An expansive role with respect to existing data

**Organizing Structure**
- Separate Results Measures from Causal Factors
- Center for Disease Control health determinants model – Causal Factors
    - Access to health care--10%
    - Environment (physical and social)--20%
    - Genetics--20%
    - Health behaviors--50%
- How Healthy Are We?
- How safe and supportive are our surroundings?
- How healthy are our behaviors?

**How Healthy Are We?**
- Years of healthy life
- Perceived mental health
- Readiness to learn

**How Safe and Supportive are our Surroundings?**
- How safe are our food, water, and air?
    - Illness from unsafe food and water
    - Air quality
- How safe and supportive are our communities?
    - Economic
    - Social connectedness
    - Injuries and death
- How supportive is our health care system?
    - Unmet need—adults, children
    - Vaccine-preventable diseases

**How Healthy are our Behaviors?**
- Do we use tobacco products?
- Do we get good nutrition?
- Are we physically active?
- Do we abuse alcohol and other drugs?

*Proposed Modifications -- General*

- General proposal
  - Crude rates per 100,000 population
    - Consistency
    - Independent of population growth
  - Age specific rates rather than age-adjusted rates, when appropriate

*General Health*

- ***"Years of Healthy Life"***
- Healthy Life Expectancy (CDC)
  - Mortality data
  - BRFSS—"Would you say your health in general is excellent, very good, good, fair, or poor?"
- Label as above rather than "Health Expectancy"

- ***"Perceived Mental Health"***--BRFSS: "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"
- Reporting more than 14 days (CDC—frequent mental distress)

- ***"Readiness to learn"***
- Proportion of children in the 3rd grade who exceed the national average on the reading and mathematics composite score.

*Surroundings—food, air, water*

- ***"Illnesses commonly associated with unsafe food and water"***
- Add "and poor hygiene"
- Rate per 100,000
- Exclude hepatitis A (it is included in vaccine-preventable diseases)

- ***"Safe drinking water"*** —% of the population for whom drinking water systems are out of compliance
- % of the population on public water supplies that are in compliance with monitoring and all water quality standards

*Surroundings--Communities*

- ***"Civic Involvement"*** –"Now we would like to know something about the groups or organizations to which individuals belong. Here is a list of various organizations. Could you tell me whether or not you are a member of each type?"
- Social Capital Index – domains
  - In the past year, did you serve on a committee for a local organization? Yes, no, DK, refused
  - In the past year, did you attend a public meeting on town or school affairs? Y, N DK, R
  - How many times, if any, did you do volunteer work in the past year? None, 1-4, 5-8, 9-11, 12-24, 25-51, 52+ DK, R

- How many times, if any did you entertain people in your home in the past year?

- ***"Interpersonal trust"*** –"In general do you think that most people try to be fair?Or try to be helpful? Or can be trusted?"
- Generally speaking, would you say that most people can be trusted or that you can't be too careful in dealing with people? Most people can be trusted, Can't be too careful, Depends (if volunteered), DK, R

- ***"High School Graduation"***
- % of students enrolled in 12th Grade in October who graduate

- ***"Injuries and death"*** --# of injuries and deaths from traffic-related, poisoning, drowning, fires and falls—inpatient hospitalizations in non-federal facilities
- "Injuries and violence"
- Rate of injury-related deaths per 100,000 population from 5 causes—breakdowns for 0-14 and 15-24 ages
- Hospitalizations for falls in adults over age 64

- ***"Crimes involving domestic relationships"*** –"# of reported crimes involving domestic relationships"
- # of offenses involving domestic violence per 100,000 population as reported from local police jurisdictions to WASPC (felonies, gross and simple misdemeanors, and violations of protection and no contact orders)

- ***"Child abuse and neglect"*** –"# of suspected cases accepted for investigation by CPS"
- Duplicated count of children in accepted referrals per 100,000 children

- ***"Homicides"*** –"# of deaths per 1,000 population due to homicide"
- Homicides per 100,000 population
- Ditto for ***Suicides***

## *Surroundings—Health Care System*

- ***"Vaccine-preventable diseases"—***"# of cases of pertussis, haemophilus influenca, measles, mumps rubella, tetanus, hepatitis A and B"
- Per 100,000 population

## *Behaviors*

- ***"Physically active"***
- BRFSS questions ask about leisure activity and work activity separately—they are not additive.

- ***"Abuse alcohol and other drugs"***
- "Binge drinking" or "heavy drinking" label